

CRITICAL ANALYSIS OF THE DISCOURSE OF

COMPETENCE

IN

PROFESSIONAL NURSING PRACTICE.

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Abstract

Title

A Critical Analysis of the Discourse of Competence in Professional Nursing Practice

Aims

This project aims to provide a critical analysis of the discourse of competence in professional nursing practice, from an historical and contemporary perspective. Through the cultivation of critical thinking, I seek to identify how power operates within this discourse to shape nurse subjectivity. This critique aims to identify the conditions that construct classifications and differences as they relate to competence in nursing practice, and to provide a collection of rich knowledge, ideas and patterned ways of thinking, that seek to assist nurses to explore themselves within the discourse. Critical analysis of the discursive practices as effects of the discourse signifies how the nurse is positioned within the discourse and provides meaning behind the existence of the discourse. An analysis of the key findings will be presented along with a conclusion and recommendations for practice.

Methodology and Theoretical Framework.

The chosen methodology is a critical analysis of the discourse of competence that draws on theoretical techniques using a Foucauldian method of critique. The theoretical framework for this project draws on the writings of French Historian and Philosopher, Michel Foucault (1926-1984), regarded as the most influential thinker of our time. I have been guided by Penny Powers (2002), and Danaher, Schirato & Webb (2000) interpretation of Michel Foucault's works.

Findings

The nursing profession is committed to developing and maintaining practitioners that are competent in their field. This focus on competence is largely driven by the nursing professions commitment toward ensuring the health and safety of the consumers of health care. Although external forces largely shape nursing, it is also strongly influenced by its own practitioners, their vision, their confidence and their image of themselves.

Conclusion

The discourse of competence in professional nursing practice is a product of professional ethics. Professional nursing competence continues to be shaped by historical and contemporary influences.

Key Words: Nursing, Competence, Discourse, Discursive practice, Power, Power knowledge, Genealogy, Governmentality.

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Table of Contents

.....	Page
Abstract.....	i
Acknowledgments	iii
Table of contents.....	iv
Chapter 1: Introduction	
Focus for the research.....	1
Introducing discourse.....	2
Society and nursing in the nineteenth century	2
Humanism.....	3
Exploring nursing education in New Zealand	3
My recollections	6
Significance of the research.....	7
Chapter Two: Literature Review	
Defining competence	9
Competence models.....	10
Factors influencing competence	11
Culture and nursing competence.....	14
Is competence enough?.....	14
Chapter Three: Methodology: Theoretical Framework	
Research Methodology	17
Theoretical Framing.....	19
Chapter Four: Structural Analysis	
The Foucauldian concept of governmentality	25
Introducing clinical and shared governance	26
Clinical governance models.....	26
Defining nursing practice.....	27
Strengthening of the clinical interface	30
Chapter Five: Genealogical Analysis	
Historical origins.....	32
Dominant discourses and power relations	33
Data Analysis and Findings	37
Conclusions and Recommendations	40
Reference List.....	43
Appendix One: Glossary of Terms.....	51

Introduction

Chapter 1

Focus for the research

Nursing competence has become a controversial issue in health care settings around the world, as it affects many aspects of the nursing profession, including education, practice and management (Khomeiran, Yekta, Kiger & Ahmadi, 2006).

In New Zealand, nursing competence became a topic of intense and frequent discussion amongst nurses in the 1990s, as professional organizations, consumer advocacy groups and a rapidly changing health care environment led nursing to continue its efforts to create safe environments for patients (Scott Tilley, 2008). There was much public discussion and media coverage relating to the perceived decline in patient safety within New Zealand hospitals at this time. Human rights, public safety and professional accountability were key issues confronting the New Zealand Health Service (Ministry of Health, 2007). In addition to this were the practice realities of increasing admission rates, higher patient acuity levels, increased workloads, chronic disease, advanced technologies, high morbidity and an informed society (KPMG Consulting, 2001). Hospitals in New Zealand and internationally are today faced with the reality of needing more nurses to meet the demands of clinical practice. As a result of this, hospitals are forced to hire increasing numbers of nurses with little or no clinical experience who are new graduates from schools of nursing, former employees of less acute care settings such as long term care facilities, nurses who have returned to nursing after many years out of the job, and an increasing number of overseas nurses with which English is not their first language (Baltimore, 2004; KPMG Consulting, 2001). All of these factors have resulted in a great need for the New Zealand government and the nursing profession as a whole, to take steps to ensure that all nurses are competent and safe to practice.

Introducing discourse

A key motivation for using discourse as an approach for carrying out this project, was knowing that discourse provides a means through which the field of nursing speaks of itself to itself (Powers, 2001). This is important, as it plays a major role in the operations of the nursing profession. Discourse generally refers to a type of language associated with an institution, and includes the ideas and statements, which express institutional values (Danaher, Schirato & Webb, 2000). Wetherell, Taylor and Yates (2001, p.84), define discourse as “a loose network of terms of reference which construct a particular version of events and which position subjects in relation to these events”. It focuses on the language people use to talk about certain aspects of their lives and aims to uncover the larger patterning of thought that structures the way in which language is used, and how the meaning of the language was created, reproduced, and interpreted by those involved in its use (Wetherell et al.). Discourse is also concerned with the ways in which language constructs objects, subjects and experiences, and most importantly includes subjectivity and a sense of self (Danaher et al.).

According to Fairclough (2001, p.187), “there are complex relationships that exist between the structures and strategies of discourse at both the local, global, social, historical and political context”. The 21st Century French philosopher and historian, Michael Foucault (1926-1984), believed that discourse can not be analyzed only in the present, and that in order to provide a clear perspective of the discourse, an historical, power and genealogical perspective must be sought (Danaher et al., 2000).

Society and nursing in New Zealand in the nineteenth century

The two decades of the 1880s and 1890s represent the beginning of social change, and signalled the beginning of professional nursing in New Zealand. This occurred in a context of rapid changes in scientific and medical knowledge (Papps & Kilpatrick, 2002). According to Papps and Kilpatrick (2002, p.11), Foucault claimed that, “power relations in modern westernised civilisation results from key conceptual changes such as the physical sciences, industrialisation, technological advances and capitalism”. It was profound

changes in society such as these, which resulted in the gradual changes of the practices of people management (Papps & Kilpatrick, 2002). These conceptual changes all took place at the same time that philosophers were describing the humanistic perspective. The emergence of the philosophical perspective called humanism, resulted in an emphasis on liberty, equality and fraternity of human beings (Papps & Kilpatrick, 2002). Together, these reconceptualizations have reframed our modern assumptions concerning power, society, science, and the notion of human agency. They continue to have a major impact on the practice of nurses and the discourse of competence in professional nursing practice (Papps & Kilpatrick, 2002). This is supported by Paterson & Zderad (2008) who discuss humanism and the profound effect humanism has had on nursing practice, from both an historical and contemporary viewpoint.

Humanism

Humanism as a discourse has greatly influenced nursing, as it is concerned with the development of human potential and well-being, and reflects all human potential and limitations of the persons involved (Paterson & Zderad, 2008). Foucault's thinking is consistent with this in terms of his concern with social justice and emancipatory practice (Danaher et al., 2000). It was important to Foucault (1926- 1984) that people were freed from any social or political restrictions, and that people had the same rights as one another regardless of factors such as culture and gender (Powers, 2001).

Humanism demands that nursing is a responsible, transactional relationship whose meaningfulness demands conceptualisation founded on a nurses existential awareness of self and of the other (Paterson & Zderad, 2008). It includes compassion, empathy and honour; however the essence of humanism is respect. Humanism is strongly bound to the principles that underpin professional nursing ethics and practice morality (Cassidy, 2008).

Exploring nursing education in New Zealand

Apprenticeship model

Historically, students of nursing learnt their craft through an apprenticeship model that was developed in the late 1800s by Florence Nightingale (Papps & Kilpatrick, 2002). The

apprenticeship model enabled the nurse to learn on the job, embracing contextual learning as a vital requirement for gaining competence in nursing practice (Longley, Shaw & Dolan, 2007). According to Glen (2009, p.498), “the apprenticeship model involved structured supervision and time for reflection; however it was believed that in reality, both training and practicing nurses were more concerned about fulfilling work roles than true reflection”. This questioned the quality of learning and the outcome of this learning on competent practices of nurses. There was much concern as to whether this model did in fact meet the needs of a changing work force (Glen, 2009). In view of this concern, a review of the apprenticeship model was carried out. This review was known as the Carpenters’ Report, 1971 (Clinton, Murrels & Robinson, 2005). This review focused on a more holistic approach to nursing. It was recognised as an outcome of this review that knowledge and understanding were viewed as essential elements of professional nursing competence (Clinton et al.). There was growing evidence at this time that nursing practices were based on rituals rather than evidenced based practice. Evidenced based practice was being recognized as an essential component of nursing competence (Papps & Kilpatrick, 2002).

Comprehensive training

The adoption of the Carpenters Report of 1979 culminated in a shift from hospital-based apprentice style training, to the polytechnic-based student focused education system (Pairman, 2002). Carpenter believed that this new curriculum would prepare the comprehensive nurse who would be able to provide competent care in a variety of health care settings. This move was aimed at improving the quality of nursing education and providing recognition for nursing as an academic profession (Glen, 2009; Papps & Kilpatrick, 2002). The comprehensive curriculum structure emphasised health promotion and prevention of illness, focusing on a ‘wellness model’ (Glen, 2009). According to Glen (2009, p.499) “this model was criticised for limiting student competence, particularly in acute care nursing, and was perceived to be responsible for a significant reduction in the student gaining competence in psychomotor skills”. This reduction in psychomotor skills of students was directly related to students spending too much time in the classroom (Glen, 2009). Psychomotor skills relate specifically to ‘doing’ and ‘motor skills’, while cognitive skills involve the use of information and knowledge. Affective skills require the nurse to

relate the importance of attitudes, emotions and values in their clinical practice. According to Gaberson and Oermann (2007, p.65) “psychomotor skills are better learnt in the practice setting, in the specific context of nursing practice”. This is supported by Khomeiran, Yekta, Kiger and Ahmadi (2006) whose recent qualitative nursing study aimed to explore factors that may influence nursing competence, revealed that nurses believed that touching the realities was the only way that they could understand and experience the challenges and actual problems that may occur with the experience. The acknowledgement of the importance of psychomotor skills in the development of the clinical competence of nurses at this time resulted in the requirements for nursing competence yet again being challenged (Glen, 2009). However, Paterson and Zderad (2008, p. 68) reminds nursing that although descriptions of competent nursing practices have historically focused primarily on the ‘doing’ aspect of the process- on the ‘techniques’ or ‘procedures’- nurses must never lose sight of the importance of the actual inter human experience of nursing in which the weight of ‘being’ is felt. According to Glen (2009, p.499) “the presence and the effect of ones presence are known more vividly by patients”.

Vision 2000

As a result of the enactment of the Education Amendment Act 1990, undergraduate nursing degrees were offered at technical institutions within New Zealand (Papps & Kilpatrick, 2002). However concern was being expressed by nursing and nursing education about the effects of restructuring the health and education sectors, and the lack of any national framework for nursing education. A national forum was developed with targets, guidelines and strategies to establish shared ownership of education targets (Vision, 2000, 1992). A framework for nursing education was eventually published in December 1992. Although this framework was never fully adopted, the Nursing Council of New Zealand (NCNZ) developed several key issues for nursing education in the 1990s. These issues included: entry to practice for registered nurses by degree, standards and competencies, post registration framework, and competence based practising certificates (Papps & Kilpatrick, 2002).

In 1998, the NCNZ stepped in and undertook the first major review of nursing education since the Carpenters Report of 1971. This review set the direction for nursing education for

the following ten to twenty years, with significant developments in post-registration nursing education. Despite these major advances in nursing education, there continued to exist a level of ambivalence about the idea of an educated nurse, and that nursing was more about exposure to a large quantity of clinical experience to establish clinical competence, rather than about undertaking intellectual activities such as post graduate study (Papps & Kilpatrick, 2002).

My recollections

As a nursing student in the late 1980s, I will always remember the great controversy that existed with the arrival of comprehensive nurses. There was concern by hospital-trained nurses at this time that comprehensive nurses did not spend enough time in clinical practice and too much time in the classroom. This raised concerns for hospital-trained nurses. Saying it of course did not necessarily mean that you could do it! Wasn't nursing a practice profession? It was a recognised concern and argument at this time that extra knowledge did not necessarily result in a more competent practitioner (Papps & Kilpatrick, 2001; Glen, 2009).

In more recent years, as the Student Nurse Coordinator (SNC) for the Bay of Plenty District Health Board (BOPDHB), and in my position of 'joint appointment' with an education provider, roles and responsibilities are linked to the assessment of nursing competence. These roles and responsibilities include supporting and training Student Nurse Educators (SNEs), and nurse preceptors, in assessing the competence of Bachelor of Nursing (BON) students during clinical placement (Bay of Plenty District Health Board, 2007). In order to assess competence, it is essential that nurses and teachers have knowledge and understanding of what constitutes nursing competence within a given context. This includes knowledge of the contextual elements of nursing practice and current trends and issues in nursing and health care (KPMG Consulting, 2001; Hood & Leddy, 2003). It is essential that preceptors and educators have well-established clinical skills and a high standard of competent nursing practice that support the effective facilitation of student learning (Gaberson & Oerman, 2007). Being familiar with the Nursing Council Competencies for Registered Nurses (RNs) and the set criteria for meeting these

competencies is essential. Preceptors and SNEs must have the knowledge of how to implement the assessment process and of the range of assessment strategies that support this process. According to McCarthy and Murphy (2007, p. 304) “there has been little time invested in determining if preceptors are aware of the range of assessment strategies and how to use the educationally devised assessment strategies to assess clinical competence”. According to Rutkowski (2007, p.37) “the assessment of competence is a complex process, based on direct observations by the preceptor and involves judgment values, which are subjective and can vary from person to person”. Rutkowski (2007, p.37) also points out that “the individual assessor’s perception of what competence should be varies greatly as the terminology relating to this concept is often ambiguous and confusing”. Assessing competence of nursing students is believed to be adhoc and poorly understood by many nurses, including nursing students (Scott Tilley, 2008).

As a result of the review of undergraduate nursing education in 2001, it was recognized that the assessment of nursing competence was a key issue for nursing. This review highlighted the need for education and service providers having a shared commitment and vision toward narrowing the gap between theory and practice (KPMG Consulting, 2001).

Significance of the research.

Research plays a significant role in professional and competent nursing practices (Winch Creedy & Chaboyer, 2002). The significance of this research is that it offers a critique of a body of nursing knowledge that will help to explain and develop an understanding of the discourse of competence from an historical and contemporary perspective. By engaging in a critical review of New Zealand and international literature, nurses will have access to data comprising ideas and patterned ways of thinking which seeks to provide meaning behind the existence of the discourse. A primary aim of this research is to cultivate critical thinking amongst nurses, through the development of self-awareness and reflection. Common themes are identified and used as evidence to support the development of recommendations that seek to advance nursing knowledge. Nurses, educators and nursing students will gain a better understanding of how power operates within a discourse to shape

a desirable nursing subjectivity, and the importance of the concept of ‘governing of the self’ in relation to developing competence in professional nursing practice.

Key conceptual changes such as industrialization, consumerism, humanism and the physical sciences, have had profound effects on shaping the discourse of competence in professional nursing practice. Nursing competence has become a dominant discourse in nursing, largely driven by consumer demand for public health and safety. It has become a controversial issue in health care settings around the world, as competence affects many aspects of the nursing profession, including education, practice and management.

The next chapter offers a critical analysis of competence in professional nursing practice. It provides a multifaceted perspective of nursing competence, and a critical gaze at past and current perspectives relating to the discourse of competence.

Literature Review

Chapter 2

This literature review offers a critical analysis of competence in professional nursing practice. It places emphasis on providing a multifaceted perspective of nursing competence, and a critical gaze at past and current perspectives of competence in professional nursing practice.

Defining competence

There are many definitions of competence in nursing that exist, and many differences in the interpretation of these definitions. According to Downie and Basford (2000, p.26), “it is these differences that add to the confusion as to what competence is and is not”. In contrast to this, Scott Tilley (2008, p. 61) points out in a review of the literature regarding the defining attributes of competence, “only 22 of the 61 articles on the topic provided a definition of competence”. Attributing to this reality was the realization that competence is multifaceted and difficult to measure, nursing careers are widely divergent with various levels of practice, different regulatory processors exist, and there is an inherent evolution of practices from the new entry level nurse to the experienced (Scott Tilley, 2008). Difficulty in defining competence is strongly linked to the reality that there are two dominant common uses for the concept of competence, which is maintenance of competence, and preparing for initial licensing (Scott Tilley, 2008).

The word competency is derived from the Middle French and Latin word *competens*. To be competent is to be proper or rightly pertinent, to have requisite or adequate ability or qualities, to be legally qualified or adequate, or to have the capacity to function or develop in a particular way (Merriam-Webster Online, n.d.). Rutowski (2007 p.35) further defines competence as “the skills and abilities to practice safely and effectively without the need for direct supervision”. However, year 2 Bachelor of Nursing Students when deemed

competent in clinical practice are assessed at a 'supervised' level according to the approach used by the Waiariki Institute of Technology (Waiariki, Institute of Technology, 2009). Nursing Council of New Zealand, (2008a, p.12) defines competence as, "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse".

Foucault (1926-1984), believed that any body of knowledge, any discipline in the human sciences that claims to produce definitions in its own area of expertise, is today faced with the observation that so-called 'empirical' definitions change historically and discontinuously (Danaher et al., 2000). In referring to a body of knowledge being 'nursing knowledge', and the discipline in the human sciences being 'nursing', nurses are confronted with the reality of many definitions of nursing competence, and of the many different interpretations of these definitions (Nursing Council of New Zealand, 2008a; Rutowski, 2007; Downie & Basford, 2000; Scott Tilley, 2008).

Competence models

The idea of a development model of competence was developed by Dreyfus and Dreyfus (1979, 1980), who defined five stages of competence in relationship to the acquisition and development of a skill (Rischel, Larsen & Jackson, 2007). These five stages of competence include, novice, advanced beginner, competent, proficient and expert (Rischel et al., 2007). Benner (1984) applied the Dreyfus Model to nursing and found similar patterns of skills acquisition. Benner found that nurses with short clinical experience seemed to be rule-governed by context free knowledge, while those with longer experience seemed to be guided by intuition and experience of similar situations (Rischel et al.). This model has been criticized for its interpretation of intuition and for the exclusion of the social elements and context of nursing practice (Rischel et al.). According to McArthur (2002, p.116), "it was evidenced based practice that de-emphasized the role of intuition, unsystematic clinical experiences, and pathophysiological rationale as sufficient grounds for clinical decision making, and as indicators of competent nursing practice". According to Avis and Freshwater (2006, p.217), "evidenced based practice over emphasizes the value of scientific evidence, while underplaying the role of clinical judgment". These authors

believe that intuition comes from experience and it is experience that supports sound clinical judgment and decision making (Avis & Freshwater; McArthur, 2002).

Benner (1984 p.304) defines competence as “the ability to perform the task with desirable outcomes under the varied circumstances of the real world”. However it was believed that Benner’s definition of competence implied that the nurse was able to complete the given practical skill or task, while understanding rationale for why the task or skill needed completing was not clearly understood (Rischel et al., 2007). Benner (1984, p.26), described the competent nurse as, “one who has been on the job in the same or similar situations for two to three years”. A recent nursing study carried out by Khomeiran, Yekta, Kiger & Ahmadi, (2006, p.68) identifying factors described by nurses as influencing competence, identified that ‘repeated experiences’ was ‘the most’ important factor influencing nursing competence. In contrast to this, Hunt and Wainwright (1994, p.84) point out that “regardless of the time spent in a particular area of practice, practices that are devoid of rationale for actions are purely task or procedure orientated and lack critical inquiry”. Rationale was now being recognised as a discourse of competence. This emergence of the importance of providing rationale is believed to have resulted in the development of critical thinking and reflection in nursing practice as discourses of competence in professional nursing practice (Cassidy, 2009).

Factors that influence competence

Critical thinking is defined by Vanetizian, (2001, p.5) as, “a tool that is used to think about a subject, situation, or project accurately and clearly, as well as deeply and broadly, in order to learn about the care requirements of that person”. Because optimal patient outcomes depend on clear and focused thinking, nurses must view themselves as thinkers and not simply doers, (Baltimore, 2004). In order to think critically, Baltimore (2004, p.137) points out that “the nurse needs to take enough time to fully understand a situation in order to be able to think critically”. With the busyness of today’s clinical environments, it is argued that the nurse’s time for reflection is challenged (Westberg & Jason, 2001). It is reflection in practice that is believed to develop a nurse’s ability to think critically.

Helping student nurses become thoughtful and competent practitioners is dependent on nurse preceptors and nurse educators helping the student become a reflective practitioner, however often the nurse educator and preceptors are not always prepared adequately for this facilitation role, thus compromising the quality of the learning experience (KPMG Consulting, 2001; Westberg & Jason, 2001).

Reasons for fostering reflection, encourages nurses to engage in self-assessment. Self-assessment is recognized as a vital assessment strategy for nurses to recognize their clinical shortcomings in terms of knowledge and practice.

According to Westberg & Jason (2001, p. 37)

Reflection enables nurses to identify and build on their existing knowledge, to identify deficits in their knowledge and errors in their thinking, integration of new understandings, accelerates learning, and the identification of unexamined assumptions and biases that can interfere with learning and competent patient care.

Reflective practices help foster collaborative relationships, and without reflective practice it is believed that nurses will not be self directed or self-critical learners, and as a result, will become incompetent and even dangerous (Westberg & Jason, 2001). Identifying what barriers there are to fostering reflective practices among nurses is essential, for example, busy clinical environments offer little time for reflection (Westberg & Jason, 2001). The importance of reflection in practice is well supported in the literature, as it relates to developing competent practices of nurses (Nicklin & Kenworthy, 2000; Meretoja, Eriksson & Leino-Kilpi, 2002; Roger, Stimpson, Topping & Porock, 2002; Westberg & Jason, 2001).

In a nursing study carried out in Iran by Memarian, Salsali, Vanaki, Ahmadi & Hajizadeh, (2007) to determine factors that influence clinical competence, two main themes emerged. These themes included internal and external factors. Internal factors were broken up into two groups, personal and work experience. Personal included knowledge and skills, ethical

conduct, professional commitment, self-respect and respect for others. Work experience included effective relationships and interest in the profession, professional responsibility and accountability. The external factors included professional and environmental factors. Professional included effective management, control and supervision, and work licensing. Environmental included provision of an effective educational system, and the provision of adequate technology. This study concluded that the acquisition of clinical competency is facilitated by professional ethics, which in turn results in observing rules, regulations and patient rights (Memarian et al.). It also identified the importance of an organized clinical environment, suitable management, effective control and supervision and appropriate training and in-service.

The context in which nursing practice occurs is viewed as a major factor in influencing competence, and must be clearly examined and understood by nurses (McCormick, Kitson, Harvey, Rycroft-Malone, Titchen & Seers, 2002). The context in which nursing practices occur takes place in a variety of settings, communities and cultures. These settings are all influenced by economic, social, political, fiscal, historical and psychosocial factors (McCormick et al.). As nursing is a practice-based discipline and clinical practice is considered to be an integral part of nursing education, then it is recognised that the clinical environment must play a leading role in the outcomes of student learning (Gleeson 2008).

Feedback from a recent international nursing conference discussing professional nursing competence assessment, identified that the evaluation of competence should be assessed using scenarios reflecting the functional context of practice (Allen, Laughler, Bridges, Johnson, McBride & Olivarez, 2008). For example, the nurse may well be able to document on paper the signs and symptoms of an evolving myocardial infarction, but when actually confronted with a crisis in clinical practice, may fail to recognise the patient's deteriorating condition. It was agreed upon that high-fidelity simulation models for the crisis component of evaluation would help address the contextual aspects of competency evaluation (Allen et al.). This is supported by Wong, Cheung, Chung, Chan, Chan, To, & Wong, (2008, p.512), who discusses the benefits of problem-based learning approaches in a simulated clinical setting.

Problem based learning is recognized for developing important professional competencies such as critical thinking, communication skills, interpersonal relations and self-assessment skills. Problem-based learning skills are believed to support a nurse's capability toward dealing with the theory practice gap. They are manifested by the collection of information, data analysis, formulation of hypothesis, validation, discussion and reflection. Problem-based learning is believed to establish dynamic teacher student relations, which result in the development of competent practices, by capturing the nature of the clinical setting and reality of critical assessment and intervention (Wong et al., 2008).

Culture and nursing competence

Key contextual elements of nursing practices incorporate such things as demographics, economics, ethics, the environment and culture (Hood & Leddy, 2003). A key contextual element of nursing practice in New Zealand is culture. Understanding the connection between culture and competent practice of nurses is essential, as the following example will signify. By 2050 it is estimated that 50% of the New Zealand population will be non-European. Specifically 30% of the births in Auckland will be of Pacific peoples (KPMG Consulting, 2001). The need for services that are culturally safe and appropriate will be driven by the demographic changes in the population and in particular the needs of and expectations of Maori and Pacific peoples and an increasing Asian population (KPMG Consulting, 2001). By 2020 there will be an increasing number of young Maori in New Zealand. It is contextual realities such as these that challenge nursing to critique current nursing services and the requirements for nursing competence, in order to meet the health needs of Maori, Polynesians and Asians. It is recognized by Maori, that the training of more Maori nurses, political representation of Maori nurses and more appropriate clinical placements; such as on Marae and Kohanga reo, will support the competent practices of future nurses (KPMG Consulting, 2001).

Is competence enough?

Despite the many definitions of competence and the determinants of what constitutes competent nursing practice Castell (2008, p.13) reminds nursing "competence on its own is

not enough”. Excellence in nursing practices is imperative, as excellence applies to ongoing scholarship and research that will enrich the profession of nursing and enhance the practices of nurses (Castell, 2008). Life long learning and research in nursing practices of today are recognised as key requirements toward maintaining and advancing nursing competence (KPMG Consulting, 2001; Avis & Freshwater, 2006; Westberg & Jason, 2000).

In referring to the Foucauldian theory relating to ‘aesthetics and subjectivity’, as presented by Danaher et al. (2000, p.136) Foucault speaks of ‘transformation of one’s self by ones own knowledge’. Foucault emphasised the importance of having the desire to be transformed by the work one does. In linking this theory to nursing and a nurses desire to provide competent care to patients, this theory suggests that valuing what one does for a job will result in nurses recognising those things that are available to them in practice that will assist the transformation of their nursing practices. Foucault suggests that believing in ones practice will assist the development of personal and professional attitudes about the importance of learning. Foucault also suggests that aesthetics is concerned with ways of presenting ourselves to ourselves and to others (Danaher et al., 2000). This challenges nurses to think about how they want to present themselves as a profession to consumers of health care, and how they want to present themselves to their own colleagues. In linking this to life long learning opportunities for nurses, nurses have an option to decide if they want to engage in certain learning opportunities such as postgraduate studies. However they are regulated to a point by their profession through mandatory learning situations such as unit based competency testing in the attempt to continually update current practices (Nicklin & Kenworthy, 2000).

According to Scott Tilley (2008, p. 58) “no mechanisms exist for most health care facilities to ensure that practitioners remain up- to- date with current best practice”. The importance of life long learning and research in nursing, with such things as post registration education for example, is recognised by learning organisations as important, however it is also recognised that life long learning and remaining up to date with current best practice, must have a collective and organisational approach to maximise competent practices of nurses

(Wilkinson, et al.). Infrastructure, support systems and processes must be in place to implement clinical governance that supports life long learning, research and information technology skills (KPMG Consulting, 2001). Information technology skills, such as computer skills and literacy skills, increase the nurses' ability to review, select and access the validity and reliability of material, in order to effectively communicate with literate patients in a competent, caring and advocacy role (KPMG Consulting, 2001).

Evidenced based practice (EBP) in recent years has become a critical concept in ethical, accountable, professional and competent nursing practice (Avis & Freshwater, 2006). Competence is measured by the nurse's ability to incorporate EBP in the care of the individual. However in critically analysing the concept of EBP, there is evidence to suggest that EBP over emphasises the value of scientific evidence while underplaying the role of clinical judgement and individual nursing expertise (Avis & Freshwater, 2006; Hardy, Garbett, Titchen & Manley, 2002). As Benner (1984, p. 36) pointed out, "knowing how to practice is a matter of expertise." Because expertise embodies an approach to intuitive and reasoned decision making, competent practices must not be solely judged on the application of EBP, but on the application of 'knowledge based practice', that is acquired not only through the 'light of theory', but through the 'light of experience' (Avis & Freshwater, 2006). As a result of an undergraduate review of nursing education, it was identified that skills such as information technologies skills be included in nursing curriculum's (KPMG Consulting, 2001).

There are many definitions of competence; however defining competence is difficult as nursing competence is multifaceted and difficult to measure. There are many factors that are attributable to the development of competent practices of nurses, and many that challenge a nurse's ability to provide competent care. Clinical governance models and risk management systems are essential in supporting preceptors, nurse educators and student nurses in facilitating and delivering competent care to patients.

The next chapter will explore the selected methodology and theoretical underpinning of the research relating to the discourse of competence in professional nursing practice.

Methodology

Theoretical Framework

Chapter Three

This research uses a conceptual framework of critical analysis that draws on the theoretical techniques of a Foucauldian inspired discourse analysis. It is based on the concept of a genealogical, structural and power analysis as it relates to the discourse of competence in professional nursing practice. I have been influenced by Foucault's notion of critique and its relevance to competence in professional nursing practice. A theoretical framework is identified, aiming to make sense of the discourse, and explains how the power perspective of the discourse approaches the problem of its own position within the power relationship it describes.

Research methodology

Discourse Analysis is a broad and complex interdisciplinary field that includes diverse theoretical and methodological approaches from linguistics, anthropology, and sociology and psychology (Stevenson, 2004). According to Fairclough (1995, p.187)

there are complex relationships that exist between the structures and strategies of discourse at a local, global, social political and historical context, and that 'both text and context need explicit and systematic analysis, and that the analysis must be based on appropriate methods and theories'.

The 'Theory of Enlightenment', as articulated by German philosopher, Immanuel Kant, influenced this notion of critique for Foucault (Danaher et al., 2000). Critique for Foucault meant engaging in an investigation into what we are, how we think, what we value, how we understand ourselves, how we treat others, what else we might be, and how we could be different from ourselves. Foucault rejected theories such as Marxism and Phenomenology, which relied on the idea of an absolute truth and ahistorical quality.

Data collection

To create the data for analysis, literature was gathered through searching clinical databases such as Ebsco Host, Ebsco A-Z, PubMed, Cinahl, Internet searches through Google Scholar, written textbooks, and corporate publications. Literature ranges from as early as 1973, capturing the historical perspective of the discourse, and up to 2009, capturing the contemporary perspective of the discourse.

Textual analysis

Textual Analysis involved summarising the chosen text by extracting the main points of an argument and by reporting on the contents of the text. Analysis of the text involved asking questions about the text in order to offer a critical interpretation of the text (Fairclough, 2001).

Ethical considerations

Critical analysis is considered subjective writing, because it expresses the writers' opinion (Polit & Tatano-Beck, 2006). It is therefore my ethical responsibility to engage in critical reading and critical writing in order to provide an accurate representation of the author's intent. There are always assumptions and biases, therefore as the researcher I will attempt to make them explicit. Ethical approval from an ethics committee was not required as there were no human participants in the research.

Cultural considerations

This critical analysis of the written text has been developed in a variety of settings and moments in history. This is important, as knowledge that exists in this form is inherently culturally bound within its own location. With any form of research undertaken by nursing, there is an ethical responsibility that the research must demonstrate responsiveness to the aspirations and diversity of Maori (Health Research Council of New Zealand, 2004). In order to be an informed researcher I have read the Health Research Strategy for Maori (2004-2008), published by Health Research Council of New Zealand. Fair and accurate representation of literature as it relates to the discourse of competence and Maori is provided. According to Powers, (2001, p 68) "the model of social agency assumed by the

discourse of nursing in the clinical encounter, is based on a model of social hierarchy and power”. The model of social agency constitutes nursing as an authority to deliver what the discipline decides is needed, not what the patient wants. Powers (2001, p.89), reminds nursing that “the discourse of ethics and practical morality provides a way of talking and acting for nurses that will resist the oppressive power relations that nursing may have over their patients”.

Theoretical framing

Discourse analysis was adopted and developed by social constructionists (Powers, 2001). It is therefore important to acknowledge social constructionism in this research. Social constructionism posits that human interactions are organized through language and meaning generated systems. There are no claims to a universal truth or reality. Individuals are viewed as responding to and holding responsibility to others within a social context. The theory of social constructionism implies that the nurses’ identity is always under construction and subjected to discursive practices such as power relations and discourses (Fairclough, 2001). The theory of ‘structuralism’, according to Foucault, was able to provide the kind of precise and systematic form of historical analysis (Danaher et al., 2000). What this means is that events, ideas and activities do not mean anything in themselves, and will only make sense when they are related to other events, ideas and activities. This theoretical approach sits well with this critical analysis of the discourse of competence, as it signifies the importance of the analysis of those things that have shaped the discourse of competence in professional nursing practices.

Psychoanalysis is a theory that aims to ‘historicize’ the different kinds of truth, knowledge, and rationality and reason that had developed in cultures. Foucault was influenced by the historicizing work of Martin Heidegger, a phenomenologist who emphasised the centrality of the social and cultural context in which truth and meaning were produced. For Heidegger, people’s ideas and activities were largely determined by the context in which they lived. However, in contrast to this, Foucault believed that what people know is limited by their context (Danaher et al., 2000). What Foucault meant by this is that knowledge is limited if it is only developed within a set context. This is relevant when studying the

discourse of competence, as it highlights the realities and challenges that nurses are faced with on a day to day basis in terms of providing competent care to people from varying cultures, contexts and backgrounds (Hood & Leddy, 2003).

The theory of 'enlightenment' for Foucault emphasised the importance of critique as a necessary attitude and form of interrogation, when used effectively results in positive change. Nursing competence is largely measured against a nurse's ability to think critically in order to provide competent care and positive health outcomes for patients (Gaberson & Oermann, 2007; Scott Tilley, 2008; Meretoja, Eriksson & Leino-Kilpi, 2002).

Looking back on the history of nursing, it is apparent that the theory of enlightenment was strongly rooted in the discipline of nursing. Holistic practices have been a discourse of competence in nursing as far back as the time of Florence Nightingale, when nurses questioned the Bio Medical Model and recognised the importance of holistic patient care (Powers, 2001). Through the nurse's own subjectivity, the discursive practice is formed (critical thinking), which continues to shape the discourse of competence (Meretoja et al., 2002). In exploring discourse I am reminded that discourse allows nursing to 'speak of itself' 'for itself'. It was the voices of nurses that resulted in developments such as the enactment of the Nurses and Midwives Registration Act 1925, which combined with the Nurses Registration Act 1901, played a pivotal role in strengthening the position of women in terms of the occupation of nursing. This resulted in nursing taking control over their profession, and removing the control out of the hands of the medical profession (Papps & Kilpatrick, 2001).

The theory of antifoundationalism has a social origin and includes self-interest which focuses strongly on people's values and beliefs (Powers, 2001). Powers interpretation of foundationalism, based on the works of Foucault's writing, is that of a disempowering ideology that is based on the empirical analytical tradition of scientific inquiry (Powers, 2001). The critique of the discourse of competence is underpinned by the theory of antifoundationalism, which focuses on making the idea of human agency the subject of

critical reflection, while also focusing on context, history, possibilities and situatedness (Powers, 2001).

Subjectivity is the term derived from psychoanalytic theory to describe and explain identity, or the self? It replaces the common sense notion that our identity is the product of our conscious self-governing self, and instead presents individual identity as the product of the discourse, ideologies and institutional practices (Danaher et al., 2000). Foucault explains how the 'field' with which the discipline works constitutes the relationships and experiences of the people within the field. According to Danaher, Schirato and Webb (2000, p. 33) "each field lays down rules and procedures, assigns roles and positions, regulates behaviours and what can be said and produces hierarchies". Foucault points out that it is important to recognise that the roles within the field precede the people who occupy the field. What Foucault meant by this was that when assuming a position within a field (nursing), then that person (nurse) enters into the processes, which regulate what occurs within the field, and their identity or subjectivity (the nurses) is shaped by the operations of that field (Danaher et al., 2000). The subjectivity of the nurse is also about how the nurse views their own subjectivity but also how the consumers of health care shape the nurses subjectivity. For example, when exploring the growth 'Model of Change', as explained by Hood & Leddy, (2003 p. 92), caring was identified as a human trait, moral imperative, interpersonal relationship, and therapeutic intervention and as an affect. It was identified that there are distinct differences between patient's perceptions of caring and that of the nurse's perception. The nurse was focused more on psychosocial skills, while the patients focused on skills, which demonstrated professional competency. These skills included being person-centered, protective, anticipatory, physically comforting and going beyond routine cares (Hood & Leddy, 2003). It is examples like these that show how consumers of health care construct the subjectivity of the nurse. The nurse assumes a certain identity within the discourse, and through the voices of consumers of health care, the discursive practices of the discourse of competence are created, positioning the nurse within the discourse.

The theory of power relations is a dominant factor to be considered in critically analysing the discourse of competence in professional nursing practice. The requirement to meet the standards set by the NCNZ that relate to clinical competency may be viewed as a message of power by some nurses (Powers, 2001). This message of power may be seen as contributing to the construction of new ways of thinking, commitment, accountability and belief around meeting the required standards set by the NCNZ. The nurse's thinking becomes constructed in such a way where the nurse begins to see his/herself differently within the role and may see others differently also. Foucault's (1926-1984) original thinking around 'the subject', was influenced by Nietzsche (1844-1900), who believed that people were not free agents who make their own meanings and control their lives; rather they have their lives, thoughts and activities scripted for them by social forces and institution, such as hospitals. However, Foucault's (1926-1984) later work considered ways in which the 'subject' could be active in crafting or negotiating their identity. Foucault believed that the self could be perfected, and that only those who were striving to perfect themselves could have access to rationality and truth. The attempt to 'perfect the self', involves the use of various regulatory bodies or 'technologies of the self', including the repeated struggle to overcome those things that threaten self-mastery. When I relate this to nursing competence, this notion of Foucault's suggests that the subject (nurse) does have control over their own subjectivity, and through their own attitude and commitment toward their own professional development the nurse has control over constructing themselves within the discourse.

In exploring the 'technologies of the self', people are able to work on themselves by regulating their bodies, their thoughts and their conduct (Danaher et al., 2000). An example of this as it relates to culturally safe practices of nurses, is the nurse who seeks to understand his or her culture, values, morals and biases, along with the knowledge of the theory of power relations and is only then capable of providing culturally safe, competent care (Nursing Council of New Zealand, 2005). The point of the technologies of the self is so that the subjects (nurses) could become competent to take up a position within society (nursing) that would not harm others, and that through the exercise of 'proper' relations, would benefit the community as a whole. In other words it was the duty of the subject

(nurse) to try to perfect the self-not only for self-improvement, but for the betterment of society. These technologies all involve self-examination and reflect a nurses understanding of and application of the ethical principles that underpin safe competent nursing practices (Memerain et al., 2007).

In a recent study carried out in Iran by Mermarian et al. (2007) to identify what nurses believed to be the factors that influenced clinical competency, nurses expressed that they needed to understand about patient's culture. This was also a factor for New Zealand nurses in the late 1980s. It was at this time that nurses in New Zealand began the process of self-examination, and through engaging in self-examination, it was identified and accepted that nurses needed to be taught cultural safety in order to provide safe and competent care to the indigenous people of New Zealand (Papps & Ramsden, 1996). This incentive was largely driven by the voices of Maori nurses at that time. Through the empowerment of the Nurses Act 1977, the Nursing Council of New Zealand made cultural safety a requirement for nursing and midwifery education. Through the setting and monitoring of standards to ensure safe and competent care for the public of New Zealand, cultural safety is a recognized requirement of competence for nurses within the "Competency Assessment Framework for Registered Nurses (Nursing Council of New Zealand, 2000). As a result of the process of self-examination by New Zealand nurses, cultural safety became a requirement for nursing and midwifery courses in 1992 (Papps & Ramsden, 1996).

Foucault also speaks of the theory of 'surveillance' (Danaher et al., 2000). This theory is identified as a process of continual watching of people's behaviours and performance so there is conformity to a set of established norms. An example of this is the role the SNE has in assessing competence of nursing students. The student's practice is assessed against Nursing Councils Competency Framework for Registered Nurses. The student is aware of the standards of practice required to obtain competence, and the student's performance of competence comes under the gaze of the SNE and preceptors who facilitates the process of assessment. The students, teachers and assessors also come under the gaze of the consumers of health care, whose own subjectivity constructs the nurse's subjectivity.

There are complex relationships that exist between the structures and strategies of discourse at both the local, global, social and political context. The text and context need explicit and systematic analysis, which is reliant on the application of appropriate research methods and theories. These Foucauldian inspired theories enable nurses to develop an understanding of the theoretical foundations that underpin competent nursing practices. This is beneficial to nurses, as by providing a theoretical framework, the nurse can decide where he or she positions his or herself within the flow of the discourse.

The next chapter will provide a structural analysis of the discourse of competence in professional nursing practice. It focuses on clinical governance models that support competent practices of nurses and how the discursive practices of these models position the nurse within the flow of the discourse.

Structural Analysis

Chapter 4

This chapter is focused on providing a structural analysis as it relates to the discourse of competence in professional nursing practice. It focuses on clinical governance models and those governing bodies, which regulate the nursing profession in New Zealand. The discursive practices of these governance models are identified, and signify how power and its practices position the nurse within the flow of the discourse.

Foucault believed that in order to conduct a discourse analysis, the following general issues within the structure of a discourse must be addressed. Powers (2001, p.56) found that

These included, the “system of differentiations”, or privileged access to the discourse; the “types of objectives” of one group over another, the “means of bringing power relations into being” that reveals surveillance systems, threats and dismissals; forms of “institutionalization” such as bureaucratic structures and “degree of rationalization” required to support power arrangements.

The Foucauldian concept of governmentality

Drawing on Foucault’s concept of ‘governmentality’, the art of governing as it applies to nursing competence draws on the links between government regulation of nurses and most importantly governance of the self (Winch et al., 2002). The concept of governmentality as it relates to nursing, would be concerned with how power and its practices are linked to the subject. Foucault was also concerned with how the ‘subject’ for example the nurse, could gain a certain amount of freedom and autonomy through understanding the purpose of governmentality and the subjects scope toward negotiating the processes of governmentality from a government regulation perspective (Danaher et al., 2000). This thinking is supported by Nursing Council of New Zealand, who as a result of a review of undergraduate nursing education in 2001, pointed out that whilst nursing practice is to a large extent shaped by external forces, it is also strongly influenced by its own

practitioners', their vision, their confidence and their image of themselves (KPMG Consulting, 2001).

Introducing clinical and shared governance

Clinical Governance is recognised as a mechanism for introducing health improvement measures over time, and a vital mechanism that plays a significant role in ensuring that nurses are competent safe practitioners (McSherry & Haddock, 2000). Shared governance as a model of nursing services is recognised as a mechanism for achieving professional accountability, continuous quality improvement, provision of high quality clinically effective care and cost effectiveness (Bamford & Porter-O'Grady, 2000). Clinical governance and shared governance models play a significant role in developing and maintaining competence in professional nursing practices (KPMG Consulting, 2001).

Clinical governance models

As a result of the concerns expressed by the New Zealand public and the nursing profession in the 1990s, the New Zealand government responded by introducing a clinical governance model known as the 'Health Professionals Competence Assurance Act (HPCA), in 2003 (Ministry of Health, 2009). The Nursing Council of New Zealand (NCNZ) is appointed by the HPCA Act 2003, as the authority in respect of the nursing profession to protect the health and safety of the public, by ensuring that nurses are safe and competent to practice (Nursing Council of New Zealand, 2008b). The HPCA Act, 2003, includes mechanisms to ensure that practitioners are competent and fit to practice their professions for the duration of their professional lives (Ministry of Health, 2007). Under the terms of this Act, the NCNZ is responsible to the public of New Zealand for the registration of nurses. Therefore the NCNZ is required to prescribe the qualifications required for the scopes of practice, and for that purpose accredits and monitors educational institutions and degrees, courses of study, or programmes (Nursing Council of New Zealand, 2008b).

Another function of the NCNZ under the HPCA Act 2003 is to set standards of clinical competence, cultural competence and ethical conduct for the profession (Nursing Council of New Zealand, 2008c). The NCNZ governs the practice of nurses, by setting and

monitoring standards of registration and enrolment (Nursing Council of New Zealand, 2008c). A competency-based framework was developed, and the NCNZ identified four generic practice domains and their associated competencies. This framework provides a practical framework by which all nurse graduates are measured against prior to seeking admission for entry to the register of nurses and for maintenance of competency thereafter (Nursing Council of New Zealand, 2008c).

Defining nursing practice

With the development of the (HPCA) Act, 2003, NCNZ was required to define nursing practice in order to determine whether a nurse had achieved or maintained the required standards of competence pursuant to section 27(a) of the (HPCA) Act, 2003) (Nursing Council of New Zealand, 2009b). Twenty-seven (a) of the (HPCA) Act, 2003, refers to restrictions on issue of a annual practicing certificate occurring if the applicant at any time failed to maintain the required standard of practice (Health Practitioners Competency Assurance Act, 2003). A new definition for nursing practice was developed in 2003, by the NCNZ. Nursing Council of New Zealand, (2009c, p.3), defined nursing practice as “using nursing knowledge in a direct relationship with nursing management, nursing administration, nursing education, nursing professional advice or nursing development policy which impact on health outcomes for New Zealanders”, This new and complex definition of nursing practice has played a major role in shaping the discourse of competence and the discursive practices that underpin competent practices of professional nurses (KPMG Consulting, 2001).

The ‘Scope of Practice for Registered Nurses’ was developed in 2004 in preparation for the implementation of the HPCA Act 2003 (Nursing Council of New Zealand, 2009a). This was recognised as essential in order to identify the vast diversity in practices taken up by nurses. With increasing specialisation in medicine and health care, there has been an increase in specialisation in nursing. Developing specialist skills of nurses has been identified in many documents as critical to the health sector in ensuring competent nurse practitioners (College of Nurses Aotearoa (NZ) Inc (2006); Oerman & Gaberson, 2006; Nursing Council of New Zealand, 2009a). Specialist nurses take on a range of new

practices and decision-making responsibilities with greater risk attached however despite this, nurses have been open to new roles that expand their practice in ways that are relevant to health services. This has lead to nurses performing procedures and roles that are outside of the 'traditional' nursing scope of practice, and falling within the 'traditional' medical scope of practice (Nursing Council of New Zealand, 2009a). It is the role of NCNZ, to specify scopes of practice, qualifications and experience following consultation with nurses, professional organizations and organizations involved in the provision of health services. Increasing specialisation of nurses is believed to be a key concern for the nursing profession, as doctors may yet again dictate the technical skills they perceive to be required of the nurse (Powers, 2001).

The NCNZ expect that all nurses continue to learn and maintain their competence in the interest of client care (Nursing Council of New Zealand, 2008c). This resulted in NCNZ, developing a 'Continuing Competence Framework.' The NCNZ recognised that achieving competence was essential, however maintenance of competence was equally as important (Nursing Council of New Zealand, 2008c). Governing bodies such as the NCNZ, use the Professional Development and Recognition Programme (PDRP) as a measure of ensuring that nurses demonstrate continuing competence (Nursing Council of New Zealand, 2008c).

Standards for 'Competence Assessment Programmes' were also developed by the NCNZ to ensure that registered nurses returning to nursing after a period of five years were required to complete an approved competence assessment programme to enable the nurse to demonstrate his or her ability to meet NZNC competencies for his or her scope of practice (Nursing Council of New Zealand, 2008a). The NZNC has developed 'Competence Assessment Programme Standards', that seek to assess the ability of overseas nurses seeking registration, or New Zealand nurses who are returning to the workforce (Nursing in New Zealand Students), Enrolled Nurses, and Nurses Assistants, in order for them to demonstrate the competencies for their scope for practice under the HPCA Act 2003.

The five standards include program content, provision of resources, teaching and learning processors, legislation and council requirements and quality improvement (Nursing Council of New Zealand, 2008b). I will engage in a critical analysis of standard one only.

Standard One relates to 'Programme Content'. This standard states that, each programme will have a programme outline that includes theory and related practice experience to enable students to demonstrate their ability to meet the NZNC competencies for their scope of practice. The content requirements are specific to New Zealand and include, the Treaty of Waitangi, cultural safety, legislation impacting on the practice of nurses in New Zealand, and an update of nursing skills and current practice (Nursing Council of New Zealand, 2008b).

Content also includes, appropriate, quality clinical placements that enable the nurse to demonstrate competence. There is a discourse around the 'appropriateness and quality of clinical placements', and how this directly impacts on the student's ability to meet the competency requirements. It has been recognised that providing appropriate clinical placements for nursing students is becoming a challenge for education and service providers (KPMG Consulting, 2001). This is believed to be due to the increasing numbers of nursing enrolments, the increase from 1100 to 1500 clinical hours, and the extra demands already placed on clinical environments (KPMG Consulting, 2001). This signifies the importance of clinical governance models, and the importance of ensuring that infrastructure, support systems, and processes are in place that supports the development of competent nursing practices (Avis & Freshwater, 2006).

The NCNZ also governs the practice of nurses through the development of the 'Code of Conduct for Nurses'. This code provides a guide for the public to assess the minimum standards expected of nurses, and a guide for nurses to monitor their own performance and that of their colleagues (Nursing Council of New Zealand, 2008a). Principle Two of the Code states that, "the nurse must act ethically and maintains standards of practice". Criteria 2.4 of 'Principle Two', states that, "the nurse must demonstrate expected competences in the practice area in which currently engaged (Nursing Council of New Zealand, 2008a, p.4).

Nursing is undertaken in complex consumer and professional environments, with nurses, being faced daily with challenges of under-resourcing, time pressures, short staffing and

unhealthy rosters. The code of ethics provides nurse with an ethical framework to prepare the nurse for situations requiring competent ethical judgement (New Zealand Nurses Organization, 2001).

Strengthening of the clinical Interface

The clinical environment has been defined by Dunn and Burnett (1995, p.1166) as, “an interactive network of forces within the clinical setting which influences the students clinical learning outcomes”. Research carried out in Britain, as far back as the 1980s (Orton, 1981; Ogier, 1982; Fretwell, 1983), identified even then, that there were positive and negative aspects of the clinical learning environment, especially in the supervision of students. The key concern and goals at that time were to ensure that models of support for student nurses in the future needed to be strengthened in order to facilitate effective learning and develop competent practitioners (Gleeson, 2008). Concerns such as these have resulted in the development of clinical governance models such as joint appointments, and collaborative nursing education models, such as Dedicated Education Units (DEU).

A joint appointment is a formalised agreement between two institutions where an individual holds a position in each institution (Cooney, Dignam & Honeyfield, 2001). The strengthening of the clinical interface is the key driver behind the international trend to establish joint appointment positions. Such appointments are believed to not only advance research and effective clinical delivery, but also contribute to ensuring nursing education is relevant to the needs of consumers, service providers and students; with the ultimate outcome being competent nursing practices (Cooney et al.).

Dedicated Education Units was an idea introduced in 1997 at the Flinders University in South Australia. This clinical governance model is identified as playing a major role in enhancing the links between service and education providers (Edgecombe, Wotton, Gonda & Mason, 1999). A DEU is an existing health care unit, such as a ward, that is designed to provide an optimal clinical learning environment by drawing on the expertise of clinicians and academics within the clinical setting. Peer teaching includes the concept of year twos and threes in clinical practice at the same time, with year three students identified as

mentors and teachers for the year two students. Peer teaching is believed to enhance skills acquisition, professional confidence, clinical reasoning and competent practices (Edgecombe et al.).

Clinical governance models are vital in protecting the health and safety of the public. They also support the development and maintenance of safe and competent nurses. The discursive practices of these clinical governance models play a pivotal role in shaping the discourse of competence in professional nursing practice. One can see how other discourses are created within the flow of the discourse.

The next chapter will provide a critical perspective of the genealogy of the discourse of competence, emphasizing the historical and power components of the discourse.

Genealogical Analysis

Chapter 5

Genealogy emphasizes the historical components of the discourse. This critical analysis aims to uncover the social processors of the historical formation of the authority of the discourse, and how it came to have the right to pronounce truth and falsity in the discourse.

In studying the works of French historian and philosopher, Michael Foucault, Foucault emphasized that discourse cannot be analyzed only in the present, and that in order to provide a clear perspective of the discourse, an historical, power and genealogical perspective must be sought. Foucault's work was not only influenced by his notion of the historical aspect of definitions, but also by Wittgenstein whose works were focused on 'definition producing discourse, and by Nietzsche, whose works focused on the historical and power components of definitions (Powers, 2001). The importance of acknowledging the works of Nietzsche in this research project is that Nietzsche believed this to be a strategy for access to hegemony or dominance of one discourse to others (Powers, 2001).

Historical origins

The name of Florence Nightingale ('The Lady with the Lamp') will remain engraved in the memory of the world. It was Florence Nightingale's efforts to provide care to the wounded and sick during the Crimean War and the impact of industrialisation on the health and well being of human beings that brought about profound changes in attitudes toward general problems of human welfare (Booth, 1995). During the 1800s, nursing competence was related to the nature of the nurse's role as a practical bedside nurse (Molley, 2009). This system of competence presumed a clearly defined purpose, the production of the bedside nurse, whose primary function was to care for the sick person (Molloy, 2009).

'Hints for Hospital Nurses', published in Britain in 1877, begins by entreating women not to enter nursing for love of notoriety, false sentiment, or even as just a means of earning a living. You were either born a nurse or you weren't (Molley, 2009). When we explore the Foucauldian perspective of 'the theory of subjectivity', this statement suggests that at this

time the nurse's subjectivity was not even considered as something that could be constructed within the flow of the discourse you were either born a nurse or you were not. In contrast to this, textbooks of the time suggested that a nurse 'was not born' but 'made' and required certain qualities of character (Molley, 2009). The nurse's character was seen as the mainstay of competence for nearly a century (Molley, 2009).

Florence Nightingale throughout her 'Notes on Nursing': 'What It Is and What It Is Not', talked about the 'good nurse' (Wood, 2002). The 'good nurse', was described in the literature as someone who possessed certain 'qualities of character'. Florence Nightingale further described the 'good nurse', as being, obedient. Nurses would learn the skill of obedience through this experience of living in a social context that involved war rule and unrest (Wood, 2002). Other key qualities of character included presence of mind, gentleness of heart and also touch accuracy, memory, observation and forethought (Molley, 2009). These 'qualities of character', are what is known as, the discursive practices of the discourse (Molley, 2009). The skills of the 'good nurse' also included, being thorough, anxious to do well, and to continue to learn. These discursive practices as they relate to competent practice saw the beginnings of scholarly inquiry in nursing and provided a measure of the outcomes of nursing care (Wood, 2002).

In a recent nursing study by Khomeiran et al. (2006) to determine what nurses of today perceive to be factors influencing professional competence, it was revealed that personal characteristics remain an essential factor. Other factors identified included, a willingness to know more, having a curious and inquiring mind, and the importance of being self-motivated to learn pre and post registration.

Dominant discourses and power relations

With dramatic changes in patient care required during the First World War and thereafter, doctors demanded educated nurses, resulting in the rise of nursing students (Hood & Leddy, 2003). This domination that medicine had over nursing at this time could be seen as having positive outcome for nursing, in that the rise of the nursing student was largely due to the voices and demands of doctors at this time (Powers, 2001).

Competence practices of nurses were determined by the values of doctors who represented the 'Bio Medical Model' and not as much by nurses who represented the 'Traditional Nursing Model'. The domination of nursing by medicine at this time was also evidenced by doctors deciding if the practices of nurses were of a standard that they determined as being appropriate. Doctors also played a large part in the setting of nursing examinations and even marked nursing papers (Papps & Kilpatrick, 2002). The nurses' subjectivity at this time was constructed largely by the beliefs of doctors (Papps & Kilpatrick, 2002).

The 'good woman' of the late 1800s was very closely linked to Christianity. In analysing the dominant discourse of Christianity and its relationship to nursing, it is clearly evident that the history of modern nursing is integrally bound up with the history of the Christian Church (Hutchison, 1998). Josephine Dolan who wrote the classic nursing text, 'Nursing in Society; A Historical Perspective', claimed, "even after nineteen hundred years it is difficult to fully comprehend the impact of the birth of Jesus Christ and his teaching had on society and on the care of the sick" (Dolan, 1973, p. 24). The care of the sick was to be placed above and before every other duty. Christianity had an influence on the role of the nurse, demonstrated by discursive practices such as 'obedience' (Dolan, 1973).

Relating this to the Foucauldian perspective of 'subjectivity', we are reminded that Foucault offered subjects (nurses) a way of thinking about and perceiving themselves, (Giddings & Wood, 2002). There was an emphasis on ethical principles for Foucault, who believed that subjects must be given the tools to develop a self and understanding of themselves within their field of work (Giddings & Wood, 2002). Foucault points out that the subjects may position themselves within the discourse or others may position the subject. When we take a critical look at the literature relating to the historical emergence of the discourse of competence, we can make clear links to the reality that 'others' positioned nurses within the discourse. In the case of Christianity, the speakers of this discourse may have had more authority to speak the discourse of competence in nursing based on the values of society at that given time in history. The actual subject (nurses) had their own subjectivity constructed for them, through the gaze of Christianity.

Throughout the 19th century, the numbers of hospitals and community associations continued to grow rapidly. Due to a resurgence of religious nursing orders, particularly the Anglican Sisterhoods, a conflict was created. With the dawn of the 'modern scientific medicine', power struggles developed between doctors and nurses. Doctors were critical of nurses, who they claimed, were more interested in the spiritual needs of the patient than the physical needs. Doctors demanded nurses who would be answerable first to them and who could accurately observe and monitor their patients. Even before the dawn of 'scientific medicine', nurses were already favouring a holistic approach to care and rejected a strictly mechanised approach to nursing (Hutchison, 1998). The dominance medicine had over nursing reinforced the handmaiden status of the nurse at this time (Powers, 2001). Doctors saw themselves as scientist (male), and the gaze of the nurse (female), personal and intimate (Powers, 2001). The personal and the intimate were devalued in the nurse, and also in the patients. However, according to Epstein & Hundert (2002, p.227), who carried out a recent study of medical physicians to determine what they believed to define their professional competence, it was revealed that doctors are now arguing that their competence is dependent on tactical knowledge rather than explicit knowledge. Doctors describe tacit knowledge as knowledge that is known but not easily explained. They identify tactical knowledge as intuition and patterned recognition (Epstein & Hundert, 2002). Doctors are now valuing those things that nurses have valued for decades, such as intuition, in contributing to competent practice (Epstein & Hundert, 2002).

Holism has become a dominant discourse of nursing competence (Hutchison, 1998). However according to Danaher, Schirato and Webb (2002, p.68), "holistic practices of nurses are a move of power and control in the name of professionalism". The discourse of holism is thought to silence critique, seeking to treat the whole person, create a speaking subject that can more easily be controlled, by requiring the patient to confess their innermost secrets. The act of confession becomes a technique of control for the nurse in order to obtain information that is deemed important in providing holistic, patient centred care.

When referring to the discourse of competence, it must be realised that this is referring to language, whether it is written or oral, however must also be realised that it is inclusive of practices. It is these practices or activities that were carried out by the nurse that signified competency in practices at this time in nursing history. It was these nursing actions that were the discursive practices of the nurse's that represented the discourse of competence (Giddings & Wood, 2002). Discursive practices of the discourse are viewed as one dimension or moment of every social practice in a dialectical relationship with the other moments of a social practice (Phillips & Jorgensen, 2002). The discursive practice reproduces or changes other dimensions of social practice just as other social dimensions shape the discursive practice. This is evidenced by the impact that public opinion has in relationship to their perceived health care needs, and how this social dimension shapes the discursive practices of nurses.

Data Analysis and Findings

Competence in professional nursing practice is multifaceted and challenging to define, due to nursing occurring in a diverse range of settings. Nursing careers are widely divergent with various levels of practice, different regulatory processors exist, and there is an inherent evolution of practices from the new entry-level nurse to the experienced. Contributing to this is the reality that there are two dominant common uses for the concept of competence, which is maintenance of competence, and preparing for initial licensing (Scott Tilley, 2008). Evidence suggests that generic competency frameworks do not represent the diverse contexts in which practice occurs.

Clinical governance models, such as the HPCA Act, 2003, are viewed as quality initiatives of government, and are primarily aimed at ensuring the competent practices of nurses and the health and safety of the New Zealand public. Maintenance of competence is viewed as a key issue in nursing, and is fundamental to public safety. Attaining, maintaining, and advancing competence is a joint responsibility between the individual nurses, employer, licensing board, educator and profession. However it is recognized that mechanisms to support life long learning, research and up to date best practices, are lacking (Scott Tilley, 2008).

There is a commitment toward reviewing Nursing Education Models in New Zealand and internationally, as nursing continues to strive to develop nursing models aimed at meeting the needs of a changing work force, evidenced by the development of initiatives such as joint appointments and Dedicated Education Units.

Assessing competent practices of nurses is challenging and is believed to be adhoc and poorly understood by clinical educators and preceptors. Nurses find the terminology relating to the concept ambiguous and confusing, and can be unaware of the range of assessment strategies (Scott Tilley, 2008). The identification of the skills required of the competent nurse is not on its own enough, as factors influencing competent practice must be known and addressed. One of these key factors is the knowledge that it must be nurses

that prescribe and measure competent practices of nurses, along with clear representation by Maori nurses.

Emphasis is given to the importance of quality of clinical placements and not just the length of clinical placements for nursing students. Nurse educators and preceptors are not always adequately prepared to carry out the role of facilitating student learning experiences, thus compromising the quality of the experience (KPMG Consulting, 2001 & Westberg & Jason, 2001).

Nurses of today and historically, are still in conflict as to whether ongoing academic studies do in fact result in competent practice, however there have been very few studies to assess this (Avis & Freshwater, 2006).

Psychomotor skills are identified as essential in developing competent practices, and are best learnt in the real practice setting, however the importance of development of competent practices is also dependent on the nurses developing cognitive and affective skills. There is a concern that nurses in training spend too much time in the classroom, thus widening the theory practice gap. There is strong evidence to suggest that problem based learning programmes are recognised as developing autonomous life long learners who are capable of dealing with the theory practice gap (Wong, Cheung, Chung, Chan, Chan, To, & Wong, 2008).

The discourse of competence and the discursive practices of the competent nurse have been shaped by the force and power of dominant discourses in society. The last major review of undergraduate nursing education was in 2001. New Zealand's environmental scanning indicates clearly profound contextual changes in New Zealand society over the last 300 years, highlighting the challenges, and responsibilities of health care providers in developing and maintaining the competent practices of nurses.

Nursing needs to think about the impact that scientific evidence (EBP) may be having on the perceptions of what constitutes competent practice, in the light of theory and experience on which to base knowledge claims.

Despite all the external influences that talk the discourse of competence, nursing competence is strongly influenced by its own practitioners, their vision, their confidence and their image of themselves (KPMG Consulting, 2001). Foucauldian theories such as ‘technologies of self’, and ‘enlightenment’, provide nurses with skills to empower themselves as individuals and as a profession, by developing the nurse’s self-awareness and confidence to constructively speak the discourse of competence.

Conclusion and Recommendations

Conclusion

Nursing practice occurs in a diverse range of settings in partnership with individuals, families, whanau and communities. Nurses are required to manage complex conditions that require a high level of scientific, professional knowledge and skills. There is strong evidence that the realities of today's clinical environments do not support competent practices of nurses. Although nursing and nursing education has learnt many lessons from the past, it is clearly evident that service providers and education providers must work collaboratively in order to develop shared clinical governance models that support competent practices of nurses now, and in the future. Clinical governance models must also provide nurses with life skills, which focus on developing the nurse's self-awareness, professional and personal subjectivity, reflection and critical thinking skills, in order for the nurse to constructively speak the discourse of competence.

Recommendations

New definitions of competence need to be developed that reinforce the value of 'continued competence' of licenses as determined by the regulatory bodies. These definitions must reflect a wide range of practice settings, initial licensing and ongoing maintenance. The development of future competency assessment frameworks must be designed to reflect the context of the clinical placement. Definitions of competency must also be expanded to include not only the capabilities, but also the achievements of desired outcomes, with measurement reflecting nursing abilities beyond technical skills.

Nursing education curriculums must ensure that 'problem based learning' programmes are developed and implemented as a means to deal with the theory practice gap. Nursing curriculums and postgraduate studies also need to include courses that teach nurses how to critique their practice, how to develop self-awareness skills, for example 'technologies of self, and how to engage in reflective practices'.

Education providers and service providers must work together to establish programs that support the preparation of SNE and preceptors. Funding must be provided to ensure this happens.

Further research studies are required to identify factors described by nurses as influencing the development of competence in practice, so that any barriers to attaining competence can be addressed. Research studies are also needed to determine if the academically focused nurse is any more or any less competent than the nurse who does not engage in postgraduate study. Evidence strongly suggests further research to determine if nurse are committed to and understand how to engage in research and up to date best practice, and if not, what is preventing this from happening.

Nursing Council guidelines for ensuring the quality of clinical placements and experiences must identify the approval of clinical providers of clinical placements, the minimum length of the clinical experience, and evaluation tools that determine student satisfaction, learning goals, objectives and outcomes.

Nurses need to critically analyse the concept of EBP, isolate and preserve what is valuable in EBP, and separate out the beneficial features from versions of scientific empiricism that undervalue personal experience as acclaim to knowledge that represents competent nursing practice.

Professional ethics must be an integral part of the nursing curriculum and measurements to evaluate competent ethical practice must be clear (Memarian, Salsali, Vanaki, Ahmadi & Hajizadeh, 2007). Courses must be offered to preceptors and SNEs in order to develop their knowledge and skills in assessing competent ethical practices of the nurse.

There must be regular review of the level of theory and practice in nursing curricula, and a requirement for consistency across institutions.

Collaborative nursing education models must be continually evaluated in order to ensure their goals and objectives, as they relate to nursing competence, are being met. It is essential that money be invested in ensuring that infrastructure, support systems and processes are in place in order to successfully implement clinical governance models (Avis & Freshwater, 2006).

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Appendix 1

Glossary of Terms

A glossary of terms is provided in order to assist the readers understanding of the terms used throughout this study.

Archaeology: the various ways in which the self has been understood differently through history (Powers, 2001).

Aesthetics: qualities and ideas that help to transform something or somebody (Danaher, Schirato & Webb, 2000).

Competence: To be proper or rightly pertinent, to have requisite or adequate ability or qualities, to be legally qualified or adequate, or to have the capacity to function or develop in a particular way (Merriam-Webster Online, n.d.).

Context: the setting in which practice takes place (McCormick, Kitson, Harvey, Rycroft-Malone, Titchen & Seers, 2002).

Discourse: a systematic body of knowledge also described as a group of ideas or patterned ways of thinking, which can be identified in textual and verbal communications, and can also be located in wider social structures (Wetherell, Taylor & Yates, 2001). A means by which the field of nursing speaks of itself, to itself (Powers, 2001).

Discourse Analysis: the examination of systematic bodies of knowledge in the tradition of critical social theory and post structural, post-modern feminism, and emphasises the power inherent in this relationship (Powers, 2001).

Discursive Practices: the activities that the nurse carries out are the discursive practices, which are framed by a particular discourse (Powers, 2001).

Emancipation: to free somebody, especially from political, legal or social restrictions (Hornby, 2000).

Genealogy: the process of analysing and uncovering the historical relationship between truth, knowledge and power (Powers, 2001).

Governance: a mechanism for introducing health improvement measures, which are capable of responding to change brought on by developments in science, medicine, nursing midwifery, management and health care resourcing (McSherry & Haddock, 2000).

Hegemony: a term for the social consensus (Danaher, Schirato & Webb, 2000).

Human Agency: all of our ideas come from outside of ourselves. We do not actually create ourselves but are created by the discourses or the language we use (Danaher, Schirato & Webb, 2000).

Michael Foucault: French philosopher and Historian of the 21st Century (Danaher, Schirato & Webb, 2000).

Power: a complex flow and set of reactions between groups and areas in society that change with circumstances and time (Danaher, Schirato & Webb, 2000).

Power-knowledge: is Foucault's concept that knowledge is something that makes us subjects, because we make sense of ourselves by referring back to various bodies of knowledge (Danaher, Schirato & Webb, 2000).

Subjectivity: pertains to the subject, and offers the subject ways of thinking about, talking about, and perceiving themselves. It is the subject's sense of self and ways of understanding themselves in relation to their world (Danaher, Schirato & Webb, 2000).

Surveillance: a process of continual watching of people's behaviour and performances so there is conformity to a set of established norms (Danaher, Schirato & Webb, 2000).

Technologies of self: mechanisms, which the individual shapes their own bodies and thoughts (Danaher, Schirato & Webb, 2000).

Text analysis: summarizing, the text by extracting the main points of an argument, by reporting about the contents of the text. Analysing a text involves asking questions about the text in order to offer an interpretation about the text. It involves analysing the content and the form of the text (Fairclough, 2001).